REQUEST FOR COPY OF
MILITARY DISCHARGE FORM

Number of copies requested _____

PLEASE PRINT

VETERAN'S INFORMATION:

Name on Record _____
First Middle Last

Date of Discharge _____ Gender _____

Requestor's Name _____

Requestor's Telephone Number (_____) _____ (MON-FRI 8:00 AM TO 5:00 PM)

Requestor's Mailing Address: _____
STREET ADDRESS CITY STATE ZIP

Relationship to Veteran: _____

Purpose for obtaining this record: _____

Requestor's proof of ID for discharge record:
(Copy of ID attached)
Type of ID _____ ID#_____

If copy is to be mailed to some other person, please complete:

Name _____ Street Address _____

City _____ State _____ Zip Code_____

_____ _____
Requestor's Signature **Date of Application**

Nancy E. Rister, County Clerk
Williamson County
P. O. Box 5089
Georgetown, TX 78627-5089